TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requester Name
Texas Health Fort Worth

Respondent Name
Arch Insurance Co

MFDR Tracking Number
M4-16-3832-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 25, 2016

REQUESTER'S POSITION SUMMARY

Requester's Position Summary: "Please submit this claim for the correct allowable per ASC Rule 134:402: Outpatient Hospital Rule 134.03, HCPC's are payable at 200% of the correct fee schedule allowable."

Amount in Dispute: $695.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett, 6404 International Parkway, Suite 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2015	96361	$695.75	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided under Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an outpatient setting.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - W3

- 193

Issues

1. The health care provider asserts the payment made by the carrier was less than the applicable fee guideline for the services provided.
2. Was the carrier's reduction supported?
3. Is the health care provider due additional payment?

Findings

1. **28 Texas Administrative Code §134.403 Hospital Facility Fee Guideline –Outpatient, is the applicable fee.**

   The service in dispute 96361 is defined – "Intravenous infusion, hydration; each additional hour."

   Section §134.403 (d) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   Section §134.403(a)(3) defines the term "Medicare payment policy" below,

   > Medicare payment policy "means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CMS developed the National Correct Coding initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The pertinent NCCI Medicare policy that was in effect on the date of service is found at www.cms.hhs.gov, *National Correct Coding Initiative Policy Manual, Chapter XI, section (B)., paragraph (5)*, which states,

   > *Hydration concurrent with other drug administration services* ***is not separately reportable****.*

   This applicable medical policy prohibits billing and payment of hydration when billed with other drug administration services.

   Review of the submitted itemized billing finds:

   - Billing for administration of the drug, Morphine Sulfate Inj 4mg/1ml on five occasions for date of service September 1, 2015
   - Billing for administration of the drug, Ondansetron Inj 4mg/2ml on one occasion for date of service September 1, 2015

2. Because the Medicare payment policy does not allow separate reimbursement of the hydration service in dispute, no separate payment is recommended.
3. As discussed above, payment for 96361 is not allowed due to NCCI edits. For that reason, no payment is due.

Conclusion

For the reasons stated above, we find that the requester has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, we have determined that the requester is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Peggy Miller	September 29, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.